Attn: Medical Marijuana Program
DHHS Division of Licensing and Regulatory Services
11 State House Station
Augusta, ME 04333

Medical Use of Marijuana Program
Patient Application/Renewal Form

Department of Health and Human Services
Maine People Living Safe, Healthy and Productive Lives
John E. Baldacci, Governor
Brenda M. Harvey, Commissioner

☐ $100 Fee Enclosed
☐ $75 Fee Enclosed MaineCare #: _____ (MaineCare # required for reduced fee)

Section 1 TO BE COMPLETED BY PATIENT

Name of patient (last, first, middle initial)

Home Address
(number and street name)
(not required if homeless)

(city, state, zip code)

e-mail address:

Telephone: (207) -

Mailing Address

(city, state, zip code)

Date of Birth:_____ Driver License Number: _____

If under 18 years of age, complete Section 2

Check One:

☐ Grow my marijuana
☐ Primary caregiver will grow marijuana
☐ Obtain marijuana from a registered dispensary

Name of registered dispensary, if selected:

Grow Location, if growing own marijuana

☐ Copy of Driver License attattched

Section 2 TO BE COMPLETED FOR MINOR APPLICANT in SECTION 1 OR PERSON UNDER GUARDIANSHIP OR DURABLE POWER OF ATTORNEY

Parent/guardian/other name (last, first, middle initial) as it appears on your driver's license

Telephone number if different than above
(207) -

Mailing Address if different than patient

☐ Parent with legal authority to make medical decisions
☐ Legal Guardian (attach copy)
☐ Durable Power of Attorney (attach copy)

☐ Copy of Driver License attached
Driver License Number: _____
Date of Birth: _____

Section 3 INDIVIDUAL PRIMARY CAREGIVER (other than a Registered Dispensary, Nursing Facility or Hospice

Name (last, first, middle initial) as it appears on Driver License, or legal name

Telephone number: (207) -

Home Address
(street)

(city, state, zip code)

Mailing Address

(city, state, zip code)

e-mail address:

Form approved 6/10

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☐ Signed release of information to speak with your physician and/or primary caregiver is attached

Describe the nature of the assistance to be provided by person named in Section 3, if you have designated a primary caregiver.

☐ Grow my marijuana ☐ Transport my marijuana from their grow site to my home ☐☐☐ Help me use my marijuana

☐ Help me prepare my marijuana into a form for ingestion ☐ Acquire my marijuana from a dispensary ☐ Assist me to take my marijuana ☐☐ Other _____

Section 3 NURSING FACILITY OR HOSPICE PROVIDER AS CAREGIVER

If you choose a nursing facility or hospice to assist you, please indicate the name:

Contact person at the facility:

☐ Check if hospice
☐ Check if nursing home

Declaration: I understand and acknowledge my duty as a patient. I understand that if my card is revoked, is voided or expires, my caregiver's identification card will be void. If I choose another primary caregiver, I must notify you and the primary caregiver card will be null and void and will be returned to the Department of Health and Human Services. I declare under penalty of perjury that the information provided on this form is true and correct. I certify that I will not sell, furnish or give marijuana to a person who is not allowed to possess marijuana for medical purposes, except as provided un the Maine Medical Use of Marijuana Act, and its rules.

Printed name of patient

_____

_____ Date _____

Signature

_____

Printed name of person legally responsible

_____

_____ Date _____

Signature

Maine Medical Use of Marijuana Program
Maine Department of Health and Human Services
Division of Licensing and Regulatory Services
41 Anthony Avenue, SHS #11
Augusta, ME 04333-0011

Release of Medical Information

As part of an application for a registry identification card to lawfully possess and/or obtain marijuana for medical use, the condition for which a physician recommends the use of marijuana for medical purposes must meet certain requirements provided by law.

I hereby give permission to a representative of the Maine Medical Use of Marijuana Program, Division of Licensing and Regulatory Services, Department of Health and Human Services, to request information from the physician(s) who has made that recommendation for medical use of marijuana to determine that it meets statutory requirements.

Date: _____

_____ _____
Patient's Name Patient's Signature

_____ _____
Or Legal Guardian's Name (if applicable) Guardian's Signature

_____
Name of Physician